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8
9 **BEFORE THE**
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. VN-2004-680

12 BLESILDA P. BATENGA
243 Harbor Beach Court
13 Santa Cruz, CA 95062

OAH No.

A C C U S A T I O N

14 Vocational Nurse License No. VN 162508

15 Respondent.

16 Complainant alleges:

17 PARTIES

18 1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this
19 Accusation solely in her official capacity as the Executive Officer of the Board of Vocational
20 Nursing and Psychiatric Technicians, Department of Consumer Affairs.

21 2. On or about July 2, 1993, the Board of Vocational Nursing and Psychiatric
22 Technicians issued Vocational Nurse License Number VN 162508 to Blesilda P. Batenga
23 (Respondent). The Vocational Nurse License was in full force and effect at all times relevant to
24 the charges brought herein and will expire on October 31, 2008, unless renewed.

25 JURISDICTION

26 3. This Accusation is brought before the Board of Vocational Nursing and
27 Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the
28 following laws. All section references are to the Business and Professions Code unless otherwise

1 indicated.

2 STATUTORY PROVISIONS

3 4. Section 2875 of the Business and Professions Code (Code) provides, in
4 pertinent part, that the Board may discipline the holder of a vocational nurse license for any
5 reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice
6 Act.

7 5. Section 118(b) of the Code provides, in pertinent part, that the expiration
8 of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during
9 the period within which the license may be renewed, restored, reissued or reinstated. Under
10 section 2892.1 of the Code, the Board may renew an expired license at any time within four years
11 after the expiration.

12 6. Section 2878 of the Code states in pertinent part that:

13 The Board may suspend or revoke a license issued under this chapter [the
14 Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:

15 (a) Unprofessional conduct, which includes, but is not limited to, the following:

16 (1) Incompetence, or gross negligence in carrying out usual nursing functions.

17 ...

18 (h) Impersonating another practitioner

19 ...

20 (j) The commission of any act involving dishonesty, when that action is related to
21 the duties and functions of the licensee.

22 ...

23 7. Section 2878.5 of the Code states in relevant part that:

24 In addition to other acts constituting unprofessional conduct within the meaning
25 of this chapter [the Vocational Nursing Practice Act] it is unprofessional conduct for a person
26 licensed under this chapter to do any of the following:

27 ...

28 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible

1 entries in any hospital, patient, or other record pertaining to narcotics or dangerous drugs as
2 specified in subdivision (b).

3 8. Section 2519, Title 16, California Code of Regulations, states that, as set
4 forth in section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a
5 ground for disciplinary action. As used in Section 2878, "gross negligence" means a substantial
6 departure from the standard of care which, under similar circumstances, would have ordinarily
7 been exercised by a competent licensed vocational nurse, and which has or could have resulted in
8 harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there
9 was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall
10 be considered a substantial departure from the above standard of care.

11 9. Section 2520, Title 16, California Code of Regulations, states that, as set
12 forth in Section 2878 of the Code, as set forth in section 2878 of the Code, incompetence is
13 deemed unprofessional conduct and is a ground for disciplinary action. As used in section 2878,
14 "incompetence" means the lack of possession of and the failure to exercise that degree of
15 learning, skill, care and experience ordinarily possessed and exercised by responsible licensed
16 vocational nurses.

17 10. Section 125.3 of the Code provides, in pertinent part, that the Board may
18 request the administrative law judge to direct a licentiate found to have committed a violation or
19 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation
20 and enforcement of the case.

21 11. DRUGS

22 **"Percocet,"** a brand of oxycodone, is a Schedule II controlled substance as
23 designated by Health and Safety Code section 11055(b)(1)(N) and a dangerous drug pursuant to
24 Business and Professions Code section 4022.

25 **"Vicodin"** is a compound consisting of 5 mg. hydrocodone bitartrate also known
26 as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety
27 Code section 11056(e)(4), and 500 mg. acetaminophen per tablet. Vicodin is also a dangerous
28 drug pursuant to Business and Professions Code section 4022.

“**Prozac**”, also known as Fluoxetine hydrochloride, is a dangerous drug pursuant to Business and Professions Code section 4022. Prozac is a psychotropic drug used to treat depression.

“**Depakote**” also known as Divalproex sodium, is a dangerous drug pursuant to Business and Professions Code section 4022. Depakote is used to reduce the incidence of seizures.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - False, Incorrect, Unintelligible Entries)

12. Respondent is subject to disciplinary action under Code section 2878(a), pursuant to section 2878.5(e) of the Code, in that while employed as a Licensed Vocational Nurse at Terreno Gardens Extended Care Center (Terreno Gardens), a skilled nursing facility located in Los Gatos, California, she made false, incorrect, inconsistent and unintelligible entries in patient records. The circumstances are as follows:

a. Patient C. B. was an 83 year old resident of Terreno Gardens Extended Care Center from March 26, 2002, to approximately September 13, 2004. Her physical condition on admission to the facility was dementia, lower back pain pertaining to degenerative joint disease, diverticulitis, hemorrhoids, colon polyps, rectocele and status post aspiration pneumonia.

(1.) On or about September 4, 2004, at 10:00 a.m., a nursing note recorded an increase in Patient CB's coccyx wound. On or about September 4, 2004, a Kaiser hospital call tracking sheet indicated that at 11:00 a.m., someone "spoke with nurse in charge, bles. She is aware of the patient wound, the patient received hygel for the wound for the last week. In her nursing assessment wound was healed." The call tracking record indicated that respondent assessed the patient's coccyx wound. However, there is no documentation in the patient's record where respondent discussed the location and gave a description of the healed wound.

(2.) A Kaiser hospital call tracking sheet regarding Patient CB contains an entry dated September 4, 2004, at 11:52 a.m., indicates that someone forwarded a physician's telephone order for "A&D ointment to decube area twice daily and as needed" to respondent. There is no entry in the nurse's notes or the physician orders to indicate that respondent

1 documented the doctor's order(s).

2 (3.) A medical records audit at Terreno Gardens conducted during the time
3 period beginning approximately on December 2004 and ending around February 2005, listed
4 77 instances wherein respondent failed to document her evaluation and medical care in the charts
5 of patients under her care. These instances include but are not limited to the following:

6 (a) On or about December 2, 2004, respondent failed to document
7 treatment of "CMP, A/C fasting lipid panel NPO" ordered for a patient in Room 20B.

8 (b) On or about December 4, 2004, respondent failed to document
9 treatment of "UA CQS in AM" ordered for a patient in Room 28B.

10 (c) On or about December 8, 2004, respondent failed to document
11 treatment of "change sup/cath bag Q 2 weeks" ordered for a patient in Room 28D.

12 (d) On February 5, 2005, respondent failed to do alert charting for patients
13 located in Rooms 23B and 28D.

14 (e) On February 6, 2005, respondent failed to do alert charting for 3
15 patients located in Rooms 28B, 23B and 25A.

16 (f) From February 12, 2005, to February 13, 2005, respondent failed to do
17 alert charting for patients located in Rooms 9B, 4A, 3A, 14B, 4B, 16B and 21 B.

18 (g) From February 16, 2005, to February 21, 2005, respondent failed to do
19 alert charting for patients located in Rooms 3A, 3B, 6B, 9A, 9B, 14B, 15B, 1A, 1B, 8A, 8B, and
20 8C.

21 (h) From February 14, 2005, to February 21, 2005, respondent failed to
22 chart the weekly nursing summary for patients located in Rooms 24A, 21A, 30B, 35A, 22A and
23 23A.

24 (4.) A medication book audit was conducted at Terreno Gardens for the time
25 period beginning on or about September 2005 and ending on or about October 2005. The results
26 of that audit cited 45 instances wherein respondent failed to chart administering medication as
27 ordered for patients under her care. These instances include but are not limited to the following:

28 (a) On or about September 21, 2005, respondent failed to chart for

1 "Regular diet & check QW" ordered for a patient in Room 1B.

2 (b) On September 21, 2005, respondent failed to chart for "Lasix x 40 mg
3 PO BID", "Trazadone 25 ms POQS", and "Lipitor 40 mg POQD" ordered for a patient in Room
4 3B.

5 (c) On September 21, 2005, respondent failed to chart for "Syrup Senna
6 10cc POQD" and "MVIC minerals 5cc POQD" ordered for a patient in Room 4B.

7 (d) On September 21, 2005, respondent failed to chart for "Gentel lube
8 eye GHS"; "B/P check QS" on two shifts; "MVI c minerals PO BID" and from September 21 to
9 September 22, she failed to chart for "DSS 250 mg. POQD" ordered for a patient in Room 6B.

10 (e) On September 21, 2005, respondent failed to chart administration of
11 "Natural tear torth 1gtt" on two occasions; "Vit c 500mg POBID", "Aquinaid 1 pk BID in 8 oz
12 fluids"; "FeSo4 325mg POQD" and "Refresh DM eyes oint" ordered for a patient in Room 7B.

13 (f) On September 21, 2005, respondent failed to chart administration of
14 "Novasource Pulmonary TID" ordered for a patient in Room 7D.

15 (g) On September 21, 2005, respondent failed to chart administration of
16 "artificial tears 1gtt" ordered for a patient in Room 8A.

17 (h) On September 21, 2005, respondent failed to chart administration of
18 "Medpass 20 60cc PO BID" ordered for a patient in Room 8B. On September 25, 2005,
19 respondent again failed to chart administration of "Medpass 20 60cc PO BID" for the patient in
20 Room 8B.

21 (i) On September 21, 2005, respondent failed to chart administration of
22 "Remeron 30 mg PO QHS" ordered for a patient in Room 8C.

23 (j) On September 21, 2005, respondent failed to chart administration of
24 "Clomidine 0.2mg PO TID" and "Hadol 1.5 mg PO QHS" ordered for a patient in Room 16A.

25 SECOND CAUSE FOR DISCIPLINE

26 (Unprofessional Conduct - Incompetence)

27 13. Respondent is subject to disciplinary action under Code section
28 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2520 (incompetence),

1 in that while employed as a Licensed Vocational Nurse at Terreno Gardens Extended Care
2 Center located at Los Gatos, California, she failed to document her assessment of patient CB's
3 decubitus ulcer including the patient's response to treatment, and failed to document a
4 physician's telephone treatment order for "A&D ointment", as set forth in paragraph 12a(1) and
5 12a(2), above.

6 THIRD CAUSE FOR DISCIPLINE

7 (Unprofessional Conduct - Gross Negligence)

8 14. Respondent is subject to disciplinary action under Code section
9 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2519 (gross
10 negligence), in that while employed as a Licensed Vocational Nurse at Terreno Gardens
11 Extended Care Center located at Los Gatos, California, she was grossly negligent in that she
12 repeatedly failed in multiple instances to follow standards of safe nursing practice as to charting
13 the care and treatment of patients assigned to her care as set forth in paragraph 13, above.

14 FOURTH CAUSE FOR DISCIPLINE

15 (Unprofessional Conduct - False, Incorrect, Unintelligible Entries)

16 15. Respondent is subject to disciplinary action under Code section 2878(a),
17 pursuant to section 2878.5(e) of the Code, in that while employed as a Licensed Vocational
18 Nurse at Courtyard Care Center (Courtyard Care), a skilled nursing facility located in San Jose,
19 California, she made false, incorrect, inconsistent and unintelligible entries in patient records as
20 follows:

21 a. **Patient EM** was given a physician's order on May 3, 2005, for "Afrin
22 Nasal Spray 2 spray each nostril "Q12 hr prn^{1/} x 5 days for sinusitis" as noted on the patient's
23 Physician Order Sheet. Courtyard Care's policies and procedures state "medications are
24 administered in accordance with the written order of the attending physician." On May 3, 2005,
25 Respondent wrote in the patients Medication Administration Record " Afrin Nasal Spray 2 spray
26

27
28 1. PRN , as used in prescriptions, is an abbreviation for the Latin phrase "pro re nata"
meaning "as needed."

1 each nostril "Q12 hr prn x 5 days for sinusitis" ... "9am" and "9pm." There was no time
2 specified in the Physician's Order. In a written declaration to the Board's investigator regarding
3 this entry, respondent stated "I put on the med sheet 9am and 9pm "PRN." It was up to the
4 nurse's discretion, their judgement, to give it, as the patient needed it."

5 b. **Patient JK** was given a physician's order on May 15, 2005, for
6 "Depokote sprinkles 250 TID 1. for mood instability 2. discussed with brother begin when
7 family gives approval." The patient's medical record indicates that this order was noted on May
8 15, 2005, at 1:30 p.m. The patient's interdisciplinary notes indicate that the patient's family gave
9 Courtyard Care permission to administer the Physician's order for Depokote on May 16, 2005. A
10 handwritten entry on the patient's medication sheet dated May 15, 2005, indicates that the first
11 dose was given to this patient beginning on the afternoon of May 15th. The medication had not
12 been received at the facility on May 15, 2005. Respondent denied administering the medication.
13 She stated that she accidentally wrote her initials on the medication sheet indicating that she
14 administered the Depokote to this patient. She did not thereafter correct the record.

15 c. **Patient NS** had Physician's Orders for Prozac for depression. On or
16 about May 12, 2005, the orders were for "Prozac 10 mg PO QHS for depression, A/B isolation,
17 refusal of ADLs and sadness over med'l condition (informed consent obtained by MD from
18 responsible party)." Another date, May 17, 2005, is noted under May 12, 2005, in the date
19 column. On May 17, 2005, the patient's dosage was changed by Physician's Order to "Prozac to
20 10 mg PO QAM" and noted on May 17, 2005, at 12:00 p.m.. On May 18, 2005, at 11:30 a.m.,
21 the physician's order was changed again to "increase Prozac to 20 mg PO QAM." The patient's
22 medication record reflects that the patient received dosages of Prozac 10 mg and Prozac 20 mg,
23 at 9:00 a.m., on May 18, 2005, administered by respondent. In a written statement to the
24 Board's investigator, respondent denied administering 30 mg of Prozac to the patient.
25 Respondent admitted that she did not document the correct amount of Prozac given to patient NS
26 during her shift on May 18, 2005. The facility's guidelines require the increased dosage to be
27 given beginning the next day, May 19, 2005.

28 d. **Patient MS** sustained a skin tear and bruising as the result of a fall

1 sustained at Courtyard Care on May 15, 2005. Respondent was the charge nurse on duty at the
2 time. A physician's order was given at 9:00 p.m. to "cleanse skin tear to left upper elbow with
3 normal saline and apply triple antibiotic ointment, cover with dry dressing daily (illegible) and
4 re-evaluate." Respondent's interdisciplinary notes for May 15, 2005, at 9:00 p.m., do not
5 document wound care for the patient. There is no indication that the physician's orders for
6 wound care were implemented during respondent's shift on May 15, 2005. Respondent also
7 documented that the patient was seen asleep and the neuro check was within normal limits. A
8 neurological status can only be obtained if the patient is awake.

9 FIFTH CAUSE FOR DISCIPLINE

10 (Unprofessional Conduct - Incompetence)

11 16. Respondent is subject to disciplinary action under Code section
12 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2520 (incompetence),
13 in that while employed as a Licensed Vocational Nurse at Courtyard Care Center located in San
14 Jose, California, she designated times for PRN order in Patient EM's medication administration
15 record, as set forth in paragraph 15a, above.

16 SIXTH CAUSE FOR DISCIPLINE

17 (Unprofessional Conduct - Incompetence)

18 17. Respondent is subject to disciplinary action under Code section
19 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2520 (incompetence),
20 in that while employed as a Licensed Vocational Nurse at Courtyard Care Center located in San
21 Jose, California, she failed to correct an inaccurate entry that she made in Patient JK's
22 medication administration record as set forth in paragraph 15b, above.

23 SEVENTH CAUSE FOR DISCIPLINE

24 (Unprofessional Conduct - Incompetence)

25 18. Respondent is subject to disciplinary action under Code section
26 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2520 (incompetence),
27 in that while employed as a Licensed Vocational Nurse at Courtyard Care Center located in San
28 Jose, California, she failed to correct a patient's (Patient NS) medication record during her shift

1 on May 18, 2005, and/or she failed to follow the facility's Medication Pass Guidelines to begin
2 the increased dose of Prozac on May 19, 2005, as set forth in paragraph 15c, above.

3 EIGHTH CAUSE FOR DISCIPLINE

4 (Unprofessional Conduct - Incompetence)

5 19. Respondent is subject to disciplinary action under Code section
6 2878(a)(1), as defined by Title 16, California Code of Regulations, section 2520 (incompetence),
7 in that while employed as a Licensed Vocational Nurse at Courtyard Care Center located in San
8 Jose, California, she failed to document that the physician's order for a patient's (Patient MS)
9 wound care was carried out, as set forth in paragraph 15d, above.

10 NINTH CAUSE FOR DISCIPLINE

11 (Impersonating Another Practitioner)

12 20. Respondent is subject to disciplinary action under section 2878(a),
13 pursuant to section 2878(h) (impersonating another practitioner) in that respondent signed off as
14 Ruth Hernandez, Director of Nursing, on an investigation follow-up form regarding an incident
15 that occurred at Courtyard Care Center. The circumstances are as follows:

16 a. On or about May 15, 2005, respondent completed an investigation follow-
17 up form documenting an incident concerning a patient who was found sitting on a bathroom floor
18 at the facility. Under the notification summary portion of the form, respondent signed the form
19 and then signed off as Ruth Hernandez on the DON signature line. In a written statement to the
20 Board's investigator, respondent admitted that she wrote Ruth Hernandez's name under the
21 supervisor approval section of the form. The form does not show otherwise that Ruth Hernandez
22 reviewed the investigation follow-up, signed the form or approved of respondent signing the
23 form for her.

24 TENTH CAUSE FOR DISCIPLINE

25 (Dishonesty)

26 21. Respondent is subject to disciplinary action under section 2878(a),
27 pursuant to section 2878(j) (dishonesty) in that respondent knowingly signed off as the DON
28 Ruth Hernandez, on an investigation follow-up record for Courtyard Care, as set forth in

1 paragraph 20a, above.

2 ELEVENTH CAUSE FOR DISCIPLINE

3 (Dishonesty)

4 22. Respondent is subject to disciplinary action under section 2878(a),
5 pursuant to section 2878(j) (dishonesty) in that respondent knowingly misrepresented complaints
6 about her nursing practice to the Board's investigator. The circumstances are as follows:

7 a. On or about October 16, 2006, respondent submitted a written statement to
8 the Board's investigator wherein she asserted under penalty of perjury that "other than the
9 previous complaint involving Resident KB at Terreno, I have not received any other complaints
10 about my nursing practice."

11 (1.) On or about October 20, 2006, the Board's investigator received a
12 certified disciplinary action record from Courtyard Care Center indicating that respondent was
13 disciplined regarding circumstances pertaining to Patient JK, Patient EM, Patient NS, and
14 falsifying the signature of Ruth Hernandez, DON, on an investigation follow-up report and
15 suspended for the following work rule violations:

16 "37. Neglect of resident care duties related to the safety, health and physical
17 comfort of residents.

18 38. Purposely falsifying company records with nursing entries know to be false.

19 46. Malicious misrepresent (sic) a material fact.

20 54. Violation of federal and state laws.

21 55. Violation of company resident care standards."

22 (2.) On or about October 21, 2005, the Board's investigator received a
23 certified disciplinary action records from 7th Avenue Center , LLC, located in Santa Cruz,
24 California. The records indicate that during the time of respondent's employment as a Licensed
25 Vocational Nurse at 7th Avenue Center, respondent was disciplined on January 27, 2000, and
26 August 10, 2000, for unprofessional conduct for yelling and disrespectful behavior towards other
27 employees. On June 14, 2001, and April 14, 2002, respondent was counseled for taking
28 excessive breaks, tardiness, no call/no-shows, failure to count narcotics at the beginning and at

1 the end of her shifts, failure to do charting including but not limited to weekly summaries. On
2 April 22, 2002, respondent was terminated from employment with 7th Avenue Center.

3 (3.) The Board's investigator received a copy of respondent's employment
4 records from Terreno Gardens Extended Care Center, in Los Gatos, California. The records
5 indicate that while employed at Terreno Gardens, respondent was disciplined as follows: on July
6 29, 2003, respondent received an associate disciplinary report, counseled and suspended for 1
7 day without pay regarding "prompt responding to resident care issues, assessing residents daily
8 and as needed"; and on February 22, 2005, respondent received a written warning and 72 hour
9 suspension without pay for incomplete charting, not responding to patients' needs and failure to
10 speak in a quiet tone.

11 b. In an interview on September 22, 2005, and in a subsequent interview on
12 October 13, 2005, with the Board's investigator, respondent denied that she had been counseled,
13 disciplined or made aware of problems with charting. When informed by the inspector that the
14 Board had evidence that contradicted her statements, respondent admitted that she had been
15 assured that the information would not be conveyed to the Board. Respondent stated that there
16 were times when she was interrupted while completing her documentation, that Terreno Gardens
17 did not allow her to work overtime to complete late documentation and that on occasion, she
18 failed to complete documentation.

19 PRAYER

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein
21 alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric
22 Technicians issue a decision:

23 1. Revoking of suspending Vocational Nurse License No. VN 162508, issued
24 to Blesilda P. Batenga.

25 2. Ordering Blesilda P. Batenga to pay the Board of Vocational Nursing and
26 Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case,
27 pursuant to Business and Professions Code section 125.3;

28 //

3. Taking such other and further action as deemed necessary and proper.

DATED: October 29, 2007



TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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